STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011804	A. BUILDING: _____ B. WING _____	R-C 08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT SYCAMORE VILLAGE LLC	611 W COUNTY LINE RD S FORT WAYNE, IN 46814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Review (PSR) to the Investigation of Complaint IN00150605. Survey date: August 26, 2014 Facility number: 011804 Provider number: 011804 AIM number: NA Survey team: Christine Fodrea, RN, TC Census bed type: Residential: 113 Total: 113 Census payor type: Other: 113 Total: 113 Sample: 3 The Hearth at Sycamore Village was found to be in compliance with 410 IAC 16.2- 5 in regard to the PSR to the Investigation of Complaint IN00150605.	{R 000}		